PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Injury _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____

Have you retained an Attorney? ( )Yes ( )No Name _____

Were there any Witnessess? ( )Yes ( )No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right Side
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
8. Were the Police notified? ( ) Yes ( ) No
9. In your own words, please describe accident : _____

   _____

   _____

   _____
10. Did you have any physical Complaints BEFORE THE ACCIDENT? ( )Yes ( )No If yes, Please describe in Detail:

    _____

    _____

    _____
11. Please describe how you felt:

    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident: _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

    _____

    _____

13. Do you have any congenital (from Birth) Factors which relate to this problem? ( )Yes ( )No. If yes, please describe: _____

14. Do you have any previous illnesses which relate to this case? ( )Yes ( )No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

15. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe: _____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ( )Yes ( )No. If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

18. Since this injury occured, are your symptoms: ( ) Improving ( )Getting Worse ( )Same

19. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( )Yes ( )No. If yes, please state type of compensation you are receiving: _____

20. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No. If yes, please describe, in detail: _____

21. Other pertinent information: _____

_____ DATE

_____ PATIENT'S SIGNATURE